

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration**

*Bureau of Health Professions
Division of Medicine and Dentistry*

***Teaching Health Center
Graduate Medical Education (THCGME) Program***

*Announcement Type: NEW
Announcement Number: HRSA-11-149*

Catalog of Federal Domestic Assistance (CFDA) No. 93.530

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2011

Application Due Date Grants.gov: December 30, 2010

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Legislative Authority: Section 340H of the Public Health Service Act, as added by Section 5508 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148)

Executive Summary

Teaching Health Centers (THC) operate medical and dental residency training programs to educate primary care providers in community-based ambulatory patient care centers. Although THCs are not limited to federally qualified health centers (HC), evidence has shown that resident physicians who train in HC settings are nearly three times as likely to practice in underserved settings after graduation. They are 3.4 times as likely to work in a HC, when compared to residents who did not train in HCs. Successful THCs have a dual mission of service and education, alignment of funding to support both patient care and training, and an organizational structure that supports the complexity of operating both a HC and a residency training program.

This announcement introduces the Teaching Health Center Graduate Medical Education (THCGME) program, a \$230 million, five-year program to support an increased number of primary care residents and dentists trained in community-based ambulatory patient care settings. These community-based settings include federally-qualified health centers, community mental health centers, rural health clinics and health centers operated by the Indian Health Service, an Indian tribe or tribal organization and entities receiving funds under title X of the Public Health Service (PHS) Act.

Payments shall be made for:

- 1) Direct expenses associated with sponsoring an approved graduate medical education training program and
- 2) Indirect expenses associated with the additional costs relating to teaching residents in such programs.

Although the program period is one year, it is HRSA's intent to fund qualified THCs for the entire five year THCGME program period pending satisfactory performance of awardees and availability of federal funds. Eligible community-based ambulatory patient care centers that operate a primary care residency program (family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics) must be listed as the institutional sponsor by the relevant medical residency accrediting body. A THC may be a central component of a consortium listed as the sponsoring institution for the residency program by the appropriate accrediting body.

The deadline for submission is December 30, 2010 at 8:00 pm ET. The applications must be submitted through Grants.gov. **The anticipated announcement date is January 15, 2011 for grants to be awarded by July 1, 2011.**

Technical Assistance Call:

Two technical assistance calls have been scheduled to help applicants understand, prepare and submit a grant application. Applicants will have an opportunity to ask questions as well.-The calls will be recorded and will remain available until the closing date of December 30, 2010.

For additional information related to technical assistance and programmatic questions please contact the program officer as listed below. Technical assistance regarding grants management issues, such as budget questions, is available from the HRSA Division of Grants Management Operations, as shown below.

HRSA Funding Opportunity HRSA-11-149

Point of Contact Information

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I. FUNDING OPPORTUNITY DESCRIPTION

1. Purpose

This announcement introduces the Teaching Health Center Graduate Medical Education (THCGME) program, which is a \$230 million, five-year program to support an increased number of primary care residents and dentists trained in community-based ambulatory patient care settings. These community-based settings include but are not limited to federally-qualified health centers, community mental health centers, rural health clinics and health centers operated by the Indian Health Service or an Indian tribe or tribal organization, and entities receiving funds under title X of the Public Health Service (PHS) Act.

Payments shall be made for:

1. Direct expenses associated with sponsoring an approved graduate medical residency training program; and
2. Indirect expenses associated with the additional costs relating to teaching residents in such programs.

Funding opportunity announcements for this program will be published on an annual basis over the five year period. New applicants as well as existing THC awardees will be eligible to apply.

2. Program Background

The Affordable Care Act establishes the Teaching Health Center (THC) program to support residency training programs in community-based settings. The THC program exists under the authority of Title III of the Public Health Service Act (PHS), as added by Section 5508 of the Patient Protection and Affordable Care Act of 2010 (P. L. 111-148), which support projects that improve the nation's access to well-trained primary care physicians and dentists by supporting community-based residency training.

The recent June 2010 Medicare Payment Advisory Commission (MedPAC) report called for increasing the amount of GME time spent in nonhospital settings, changes to GME funding to meet goals such as community-based care, and increasing the diversity of the pipeline of health professionals. (MedPAC 2010)

The THC program can help to address the primary care workforce shortage and increase residency training in community-based settings. The THC model has a long history with several successful THCs dating back to the 1980s. (Engebretsen 1989, Zweifler 1993) However, the growth of THCs has been limited due to difficulty bringing together the dual mission of training and service in HCs, administrative complexity, and a lack of financial resources. (Morris 2009) Recent studies have demonstrated the increased likelihood of THC graduates to practice in HCs and other underserved settings, the challenges and benefits of bringing HCs and residency programs together, and the characteristics of existing THCs. (Morris 2008, Rieselbach 2010)

Successful THCs have common elements, foremost of which is an institutional commitment to a dual mission of medical education and service to an underserved patient population, including

underrepresented minority and other high risk populations. In addition, there is significant patient- and community-based input into THC operation and management; and THCs have also demonstrated progress toward innovative models of patient care delivery such as the patient-centered medical home, implementation of electronic health records, population-based care management, and use of interdisciplinary team-based care. (Morris 2009)

References

Engebretsen BJ. Family medicine and community health centers: A natural alliance. *Family Medicine* 1989; 21:417-8.

Report to the Congress: Aligning Incentives in Medicare (June 2010). Medicare Payment Advisory Commission. (available at <http://www.medpac.gov>).

Morris CG and Chen FM. Training Residents in Community Health Centers: Facilitators and Barriers. *Annals of Family Medicine* 2009; 7:488-94. (available at <http://www.annfammed.org/>).

Morris CG, Johnson B, Kim S, and Chen FM. Training Family Physicians in Community Health Centers: A Health Workforce Solution. *Family Medicine*. 2008; 40(4):271-6 (available at <http://www.stfm.org/fmhub/>).

Rieselbach RE, Crouse BJ, Frohna JG. Health centers: Addressing the workforce crisis for the underserved. *Annals of Internal Medicine* 2010; 152:118-22.

Zweifler J. Balancing service and education: Linking community health centers and family practice residency programs. *Family Medicine* 1993; 25:306-11.

II. AWARD INFORMATION

1. Type of Award

Funding will be provided in the form of a formula grant.

2. Summary of Funding

This THCGME Program opportunity will provide payments for expenses incurred in Federal Fiscal Year 2011. The initial period of support and budget period will be July 1, 2011 through September 30, 2011. [Funds for the period of October 1, 2011 through September 30, 2012 will be available through a post-award renewal that will provide payments for expenses incurred through September 30, 2012.] The number of THCs and residents funded will depend upon the number of qualified THCs who are deemed eligible for GME payments. Total THCGME payments cannot exceed the amount apportioned. The anticipated announcement date is January 15, 2011 for grants to be awarded by July 1, 2011. It is HRSA's intent to fund

qualified THCs for the entire five year THCGME program period (Federal Fiscal Years 2011 through 2015) pending satisfactory performance of awardees and availability of federal funds.

Funding can only be used for the costs of new residents in a newly-established THC or an expanded number of residents in a pre-existing THC. The baseline number of residents for pre-existing THCs is the number of residents enrolled at the end of the 2009-2010 academic year. Eligible THCs will report to HRSA the number of full-time equivalent (FTE) residents during the Federal Fiscal Year. The Affordable Care Act directs HRSA to calculate a THC per-resident amount, adjusted by locale, for each eligible applicant. The direct GME payment will be the product of FTE and the per-resident amount. Indirect costs will also be determined by HRSA. Until the direct and indirect formulas are accurately calculated, HRSA estimates the interim GME payment to be up to \$150,000 per resident FTE per year, including direct and indirect costs, subject to later reconciliation with cost information. This amount may be adjusted each year, subject to the availability of funds. In addition, the total amount of available funding will be divided amongst all eligible applicants. As a result, it is possible that funding for THCGME may fluctuate over time, depending upon the number of eligible applicants.

The Affordable Care Act also clarifies the relationship between THCGME funding and other payments that support THC residents, including but not limited to Medicare, Medicaid and Children's Hospital GME. THCGME payments can supplement, but not duplicate, GME payments from other sources. However, if the hospital claims the THC residents' inpatient time, the THC cannot also claim that time from HRSA. HRSA encourages applicants to coordinate closely with affiliated teaching hospitals in order to avoid over-reporting of THCGME FTE. Over-reporting of FTE and subsequent over-payment will be subject to the THC reconciliation process and will result in the recoupment of THCGME payments. In addition, HRSA will work closely with CMS to maintain counts of resident FTE in teaching hospitals affiliated with THCs.

Reconciliation: The authorizing legislation provides for a reconciliation process, through which overpayments may be recouped and underpayments may be adjusted. (See section 340H (f) of the Public Health Service Act.) The reconciliation process is based on the number of residents reported by the THC for the Federal Fiscal Year to determine the final amount payable to the THC for the Federal Fiscal Year. The final amount shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1886(d) of the SSA and is subject to review under that section. HRSA will provide awardees with further information regarding the reconciliation process.

III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Eligible entities include community-based ambulatory patient care centers that operate a primary care residency program. Specific examples of eligible entities include, but are not limited to:

- Federally qualified health centers, as defined in section 1905(1)(2)(B) of the Social Security Act

- Community mental health centers, as defined in section 1861(ff)(3)(B) of the Social Security Act
- Rural health clinics, as defined in section 1861(aa) (2)of the Social Security Act
- Health centers operated by the Indian Health service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act)
- An entity receiving funds under title X of the Public Health Service Act.

The THCGME program will support high-quality primary care residency training in high-need, underserved communities. The list of entities above is not exclusive, but does reflect the intent of the program to provide training in settings such as those served by the institutions listed.

Only specific residency training programs are eligible. According to the authorizing legislation, “Primary care residency program” refers to an accredited graduate medical residency training program in:

- Family medicine
- Internal medicine
- Pediatrics
- Internal medicine-pediatrics
- Obstetrics and gynecology
- Psychiatry
- General dentistry
- Pediatric dentistry, and
- Geriatrics

In addition, the eligible entity must be listed as the institutional sponsor by the relevant accrediting body, including the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or the American Dental Association (ADA). Corporate entities such as a GME consortium collaborating with a health center and hospital in operating one or more primary care GME programs may also be eligible THCs. The corporate entity may be listed as the institutional sponsor, but must ensure that the community-based ambulatory training site is a central partner in the consortium. THCGME payments must directly support the THC ambulatory training site. The goals of the consortium must include high quality training in teaching health centers and demonstration of new models for community-based GME. The applicant **MUST** provide documentation that they are accredited, and must name their accrediting body and date of accreditation for verification purposes (see Attachment 2).

Eligible residents are either a graduate of an accredited medical school in the U.S. or Canada; or have passed the United States Medical Licensing Examination (USMLE) Parts I & II (international or foreign medical graduates).

2. Cost Sharing/Matching

Cost sharing or matching is not required.

3. Other

Any application that fails to satisfy the deadline requirements referenced in *Section IV.3* will be considered non-responsive and will not be considered for funding under this announcement.

Funding Limitations: If a THC-affiliated teaching hospital receives GME funding from Medicare or other sources for the new THC residents, the THC cannot claim that portion of the time for HRSA GME payments.

Audit Authority: The Secretary may audit a qualified THC to ensure the accuracy and completeness of the information submitted in response to this application and in the report required by this application.

IV. Application and Submission Information

1. Address to Request Application Package

Application Materials and Required Electronic Submission Information

HRSA *requires* applicants for this funding opportunity announcement to apply electronically through Grants.gov. All applicants *must* submit in this manner unless they obtain a written exemption from this requirement in advance by the Director of HRSA's Division of Grants Policy. Applicants must request an exemption in writing from DGPWaivers@hrsa.gov, and provide details as to why they are technologically unable to submit electronically through the Grants.gov portal. Your email must include the HRSA announcement number for which you are seeking relief, the name, address, and telephone number of the organization and the name and telephone number of the Project Director as well as the Grants.gov Tracking Number (GRANTXXXX) assigned to your submission along with a copy of the "Rejected with Errors" notification you received from Grants.gov. **HRSA and its Grants Application Center (GAC) will only accept paper applications from applicants that received prior written approval.** However, the application must still be submitted under the deadline.

Refer to HRSA's *Electronic Submission User Guide*, available online at <http://www.hrsa.gov/grants/userguide.htm>, for detailed application and submission instructions. Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process.

Applicants must submit proposals according to the instructions in the Guide and in this funding opportunity announcement in conjunction with Application Form SF-424 Short. The forms contain additional general information and instructions for applications, proposal narratives, and budgets. The forms and instructions may be obtained from the following site by:

- (1) Downloading from www.grants.gov, or

- (2) Contacting the HRSA Grants Application Center at:
910 Clopper Road
Suite 155 South
Gaithersburg, MD 20878
Telephone: 877-477-2123
HRSAGAC@hrsa.gov

Specific instructions for preparing portions of the application that must accompany Application Form SF-424 Short appear in the “Application Format” section below.

2. Content and Form of Application Submission

Application Format Requirements

The total size of all uploaded files may not exceed the equivalent of 40 pages when printed by HRSA, or a total file size of 5 MB. This 40-page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard forms are NOT included in the page limit.

Applications that exceed the specified limits (approximately 5 MB, or 40 pages when printed by HRSA) will be deemed non-compliant. Non-compliant applications will not be considered under this funding announcement.

Application Format

Applications for funding must consist of the following documents in the following order:

SF-424 Short Form – Table of Contents

- It is mandatory to follow the instructions provided in this section to ensure that your application can be printed efficiently and consistently for review.
- Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered under this funding opportunity announcement.

- For electronic submissions no Table of Contents is required. HRSA will construct an electronic Table of Contents in the order specified.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Application for Federal Assistance (SF-424 Short)	Form	Pages 1, 2 & 3 of the SF-424 Short face page.	Not counted in the page limit.
Project Summary/Abstract Attachment Form	Form	Supports the upload of the Project Abstract	Not counted in the page limit.
Project Summary/Abstract	Attachment	Can be uploaded in Project Summary/Abstract Attachment Form	Required attachment. Counted in the page limit. Refer guidance for detailed instructions. Provide table of contents for this document
Project Narrative Attachment Form	Form	Supports the upload of Project Narrative document	Not counted in the page limit.
Project Narrative	Attachment	Can be uploaded in Project Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions. Provide table of contents specific to this document only as the first page.
Project/Performance Site Location(s)	Form	Supports primary and 29 additional sites in structured form.	Not counted in the page limit.
Additional Performance Site Location(s)	Attachment	Can be uploaded in the SF-424 Performance Site Location(s) form. Single document with all additional site location(s)	Not counted in the page limit.
SF-424B Assurances - Non-Construction Programs	Form	Supports assurances for non-construction programs.	Not counted in the page limit.
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
HHS Checklist Form HHS – 5161-1	Form	Pages 1 & 2 of the HHS checklist.	Not counted in the page limit

- To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
- Evidence of Non-Profit status and invention related documents, if applicable, must be provided in the other attachment form.
- Additional supporting documents, if applicable, can be provided using the available rows. Do not use the rows assigned to a specific purpose in the program funding opportunity announcement.
- Merge similar documents into a single document. Where several pages are expected in the attachment, ensure that you place a table of contents cover page specific to the attachment. The Table of Contents page will not be counted in the page limit.

Attachment Number	Attachment Description
Attachment 1	Documentation of number of eligible FTEs.
Attachment 2	Documentation of accreditation and standing from the Residency Review Committee (RRC).
Attachment 3	Other Relevant Documents to Project including supporting documentation of indirect graduate medical expenses.
Attachment 4	Position Descriptions and biographical sketches for key staff

Application Format

Applications for funding must consist of the following documents in the following order:

i. Application Face Page

Complete Application Form SF-424 Short provided with the application package. Prepare according to instructions provided in the form itself. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93.530.

DUNS Number

All applicant organizations are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a unique nine-character identification number provided by the commercial company, Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found at <http://fedgov.dnb.com/webform> or call 1-866-705-5711. Please include the DUNS number in item 8c on the application face page; on the application face page. Applications *will not* be reviewed without a DUNS number. Note: A missing or incorrect DUNS number is the number one reason for applications being “Rejected for Errors” by Grants.gov.

Additionally, the applicant organization is required to register annually with the Federal Government’s Central Contractor Registry (CCR) in order to do electronic business with the Federal Government. It is extremely important to verify that your CCR registration is active. Information about registering with the CCR can be found at <http://www.ccr.gov>.

ii. Table of Contents

The application should be presented in the order of the Table of Contents provided earlier. Again, for electronic applications no table of contents is necessary as it will be generated by the system. (Note: the Table of Contents will not be counted in the page limit.)

iii. Application Checklist

Complete the HHS Application Checklist Form HHS 5161-1 provided with the application package.

iv. Staffing Plan and Personnel Information

Applicants should present a staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. Position descriptions that include the roles, responsibilities, and qualifications of proposed project staff, and Table of Organization, must be included in Attachment 4. Biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included in Attachment 4.

v. Assurances

Complete Application Form SF-424B Assurances – Non-Construction Programs provided with the application package.

vi. Certifications

Use the Certifications and Disclosure of Lobbying Activities Application Form provided with the application package.

vii. *Project Abstract*

Provide a one page summary of the application. Because the abstract is often distributed to provide information to the public and Congress, please prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include the following:

- (1) A four or five sentence overview of the Teaching Health Center
- (2) Specific, measurable objectives which the Teaching Health Center will accomplish;
- (3) How the Teaching Health Center will accomplish its objectives during the funding period.

Please provide the following at the top of the abstract:

- Project Title
- Applicant Organization Name
- Training Discipline (family medicine, internal medicine, pediatrics, etc.)
- Project Director
- Address
- Contact Phone Numbers (Phone and Fax)
- Email Address
- Organizational Website Address, if applicable

The project abstract must be single-spaced and limited to one page in length.

viii. *Project Narrative*

This section provides a comprehensive framework and description of all aspects of the proposed program. It should be succinct, self-explanatory and well organized so that HRSA staff can understand the proposed objectives and expected outcomes.

Use the following section headers for the Narrative:

INTRODUCTION

In this section, the applicant must provide the purpose of the proposed project.

ORGANIZATIONAL INFORMATION

In this section, the applicant must provide information that will be used to support the cost estimates associated with the graduate medical education programs. Organizational information shall include, but is not limited to:

- (1) Applicant organization's structure, including how eligibility criteria listed on page 8 are met and the delivery model of primary care for underserved populations and training for primary care physicians and/or dentists; for example, the applicant may choose to describe significant effort and progress toward innovative models of patient care delivery such as the patient-centered medical home, including but not limited to implementation of

electronic health records, population-based care management, and use of inter-professional team-based care. Describe the organization's plans to increase or expand its residency training capacity.

- (2) Overview of the current curriculum; for example, longitudinal teaching curriculum on new models of care such as the patient centered medical home and inter-professional team-based care, or effective communication through enhanced cultural competency; may include novel patient access venues such as home care, and technological solutions including electronic communications such as tele-visits. Describe curricular evaluation which may include assessments specifically addressing parameters such as quality of care, patient safety, cultural, and other competencies. If applicable, describe affiliations to academic health centers or other academic institutions and their contribution to the quality of training.
- (3) Description of the current ambulatory care and community-based training settings and patient population;
- (4) Existing applicant resources; and
- (5) Characteristics of successful THCs should also be addressed in this section of the narrative, including:
 - a. Demonstrated institutional commitment to a dual mission of education and service;
 - b. Demonstrated commitment to an underserved patient population, including underrepresented minority and other high risk populations; and
 - c. Patient- and community-based input into THC operation and management.

METHODOLOGY FOR CALCULATING PAYMENTS

Direct Graduate Medical Expense Amount

The awards under the THCGME program for direct graduate medical expenses will be reconciled at the end of the project period using a formula.

$$\text{Direct graduate medical expenses} = (A) \times (B)$$

A = the updated national per resident amount. The updated national per resident amount is determined by dividing the national average per resident amount computed under section 340E(c)(2)(D) of the Public Health Service Act into a wage-related portion and a non-wage related portion by applying a proportion determined by the Secretary; the wage-related portion is multiplied by the factor applied under section 1886(d)(3)(E) of the Social Security Act (but without application of section 4410 of the Balanced Budget Act of 1997 during the preceding fiscal year for the THC's area). That value is then added to the non-wage portion.

The wage index and labor related share of the cost of the resident used to define wage-related portion is computed by the Centers for Medicare and Medicaid Services (CMS).

B = the average number of full-time equivalent residents in the THC's graduate approved medical residency training program as determined under section 1886(h)(4) of the Social Security Act (without regard to the limitation under subparagraph (F) of such section) during the fiscal year.

Applicants must provide documentary evidence of the number of full-time equivalent residents claimed in Attachment 1. Resident FTE is measured in terms of time worked during a residency training year; it is not a measure of the number of individual residents who are working. Applicants may count the time that the residents are training at the THC and other institutions, as long as it is not claimed by other sources, including children's hospital GME program or through the CMS GME program. **Applicants are not permitted to receive payment from multiple sources for the same time. Failure to provide sufficiently clear and documented evidence of FTEs will make the applicant ineligible for an award.**

Indirect Graduate Medical Expense Amount

The awards under the THCGME program for indirect graduate medical expenses associated with the additional costs of teaching residents for a fiscal year will be reconciled at the end of the project period using a formula to be developed by the Secretary, subject to the availability of funds. The interim payment of up to \$150,000 per resident FTE per year includes direct and indirect costs.

Hospitals base the indirect graduate medical expense rate on inpatient data and the intern/resident-to-bed (IRB) ratio. However, THCs will need to create a different basis for establishing the indirect cost rate associated with teaching residents.

In order to inform HRSA's work to develop an accurate formula for determining indirect cost payments, applicants are encouraged to provide a narrative explanation of and estimates of the direct and indirect training costs relative to supporting a primary care residency program in qualified THCs.

Such costs may include, for example:

- Infrastructure changes necessary to accommodate teaching capacity not including construction;
- Technological and data costs necessary to support teachers and students;
- Lost treatment capacity resulting from teaching requirements;
- Lost wages for physician staff resulting from teaching requirements;
- Evaluation costs for evaluating outcomes resulting from providing GME in the THC setting;
- Costs associated with curriculum development; recruitment and retention of residents and faculty, etc.; and
- Other elements, as necessary.

Applicants are invited to suggest a workable alternative to the IRB ratio tailored to the teaching hospital setting.

After receipt of all applications, the Secretary plans to promulgate regulations, providing interested parties with notice and an opportunity for comment, which will provide a methodology for calculating the indirect graduate medical expenses. In order to implement the program immediately and provide funding in FY 2011, and as authorized by section 340H(d)(3), the Secretary plans to make interim awards based on an estimate of indirect medical expenses submitted by applicants. The authorizing statute provides for a reconciliation process, through which overpayments may be recouped and underpayments may be adjusted. See section 340H(f) of the Public Health Service Act. The reconciliation process is based on changes to the number of residents reported by the THC; however in the first year of implementation, the reconciliation process will be utilized to ensure no overpayment of indirect graduate medical expenses.

EVALUATION PLAN

Evaluation will be a major component of this program; applicants will be expected to provide outcome information on the effects of this funding. Measureable outcomes will include practice patterns of graduates such as whether they are providing primary care, and whether they are serving in safety net settings one and five years after completion. It may also include outcomes such as creation of interprofessional teams that provide person-centered care, improvement in quality parameters, improvement in patient outcomes, and improvement in use of electronic medical technology. Reporting will be required on an annual basis. All applicants must agree to track the practice patterns of graduates for five years following the completion of their residency training. Eligible applicants will receive specific reporting requirements in their Notice of Grant Award.

The evaluation will demonstrate if the program is functioning according to its purpose and objectives. Applicants must present an evaluation plan to collect and analyze information on the measurable outcomes listed in the previous paragraph. The plan should address the following elements:

- (1) Evaluation Technical Capacity: current evaluation experience, skills, and knowledge of individual(s) responsible for conducting and reporting evaluation efforts;
- (2) Evaluation Methods: evaluation questions; instruments/tools used; primary/secondary data sources, milestones, timeline, etc.;
- (3) Quality Assurance Plan: process to validate data collection and results; and
- (4) Evaluation Report: written description of evaluation activities, results, challenges, and recommendations.

Failure to provide the report or a determination that the report contains incomplete or inaccurate information will result in a reduction of the amount payable by at least 25%. Prior to imposing any such reduction, the applicant will be provided notice and an opportunity to provide the required information within 30 days beginning on the date of such notice.

ix. Attachments

Please provide the following items to complete the content of the application. Please note that these are supplementary in nature and are not intended to be a continuation of the project narrative. Be sure each attachment is labeled clearly.

Attachment 1: Documentation of number of eligible resident FTEs. Resident FTE is measured in terms of time worked during a residency training year; it is not a measure of the number of individual residents who are working. Applicants may not count resident FTE if any time spent training at other institutions, including children's hospitals or other hospitals, is claimed either through the children's hospital GME program or through the Medicare GME program. If THC residents' time is not being claimed by other sources, the applicant may claim the entirety of the THC residents' time. **Applicants are not permitted to receive payment from multiple sources for the same time.**

Documentation includes the following information:

- Justification for resident FTE measurement based on the resident's rotation schedule;
- The resident's rotation schedule for the academic year that covers the period in which the resident is being claimed for THCGME purposes. The rotation schedule must include for each rotation: the rotation, rotation location, and the start and end dates of the rotation [e.g., the rotation and inclusive (rotation) dates the resident is assigned to the THC and the rotation and inclusive (rotation) dates the resident is assigned to hospitals, or other non-THC setting(s) during the current academic year];
- Documentation (e.g. rotation schedule) to support the amount of time a resident will spend in THC, hospitals, or other non-THC setting(s) during the current academic year;

Pre-existing THCs must include the baseline number of eligible FTEs as of June 1, 2010.

Provide the aggregate number of FTE for the academic year beginning July 1, 2011. Project the future program size over the next five years, including the continuation of training for THC residents funded in FY2011.

Failure to provide sufficiently clear and documented evidence of FTEs will make the applicant ineligible for an award.

Attachment 2: Documentation of accreditation and standing with the Residency Review Committee (RRC). A copy of the letter of approval or accreditation from the appropriate accrediting agency.

Attachment 3: Other Relevant Documents to Project including supporting documentation of indirect graduate medical education expenses. Applicants applying under a GME consortium should include a copy of the institutional agreement between the consortium and THC.

Attachment 4: Position Descriptions and Biographical sketches for key staff. *Keep each to one page in length as much as is possible.* Include the role, responsibilities, and qualifications of proposed project staff

3. Submission Dates and Time

Application Due Date

The due date for applications for all programs under this grant announcement is December 30, 2010 by 8:00 P.M. ET. Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by your organization's Authorized Organization Representative (AOR) through Grants.gov and has been validated by Grants.gov on or before the deadline date and time.

The Chief Grants Management Officer (CGMO) or designee may authorize an extension of published deadlines when justified by circumstances such as natural disasters (e.g., floods or hurricanes) or widespread disruptions of service, such as a prolonged blackout. The CGMO or designee will determine the affected geographical area(s).

Late applications:

Applications which do not meet the criteria above are considered late applications and will not be considered in the current competition.

4. Intergovernmental Review

This grant program is not subject to the provisions of Executive Order 12372, pertaining to Intergovernmental Review of Federal Programs, as implemented by 45 CFR 100.

5. Funding Restrictions

Funding can only be used for the costs of new residents in a newly-established THC or an expanded number of residents in a pre-existing THC.

THCGME payments can be made in addition to existing GME payments from other sources. However, if the hospital claims the THC residents' inpatient time, the THC cannot also claim that time from HRSA. HRSA will work closely with CMS to maintain counts of resident FTE in teaching hospitals affiliated with THCs. This will ensure accurate accounting as well as discourage teaching hospitals from transferring existing GME slots to non-primary care residency training.

Applications that do not clearly demonstrate that eligibility requirements are met will be considered non-responsive and will not be considered for funding under this announcement.

6. Other Submission Requirements

As stated in Section IV.1, except in rare cases HRSA will no longer accept applications in paper form. Applicants submitting for this funding opportunity are *required* to submit *electronically*

through Grants.gov. To submit an application electronically, please use the <http://www.Grants.gov> application site. When using Grants.gov you will be able to download a copy of the application package, complete it off-line, and then upload and submit the application via the Grants.gov site.

It is essential that your organization *immediately register* in Grants.gov and become familiar with the Grants.gov site application process. If you do not complete the registration process you will be unable to submit an application. The registration process can take up to one month.

To be able to successfully register in Grants.gov, it is necessary that you complete all of the following required actions:

- Obtain an organizational Data Universal Number System (DUNS) number
- Register the organization with Central Contractor Registry (CCR)
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's CCR "Marketing Partner ID Number (M-PIN)" password
- Register an Authorized Organization Representative (AOR)
- Obtain a username and password from the Grants.gov Credential Provider

Instructions on how to register and apply, tutorials, and frequently asked questions (FAQs) are available on the Grants.gov web site at www.grants.gov. Assistance is also available from the Grants.gov help desk 24 hours a day, 7 days a week (excluding Federal holidays) at support@grants.gov or by phone at 1-800-518-4726.

Formal submission of the electronic application: Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by your organization's AOR through Grants.gov and has been validated by Grants.gov on or before the deadline date and time.

It is incumbent on applicants to ensure that the AOR is available to submit the application to HRSA by the published due date. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the deadline. Therefore, you are urged to submit your application in advance of the deadline. If your application is rejected by Grants.gov due to errors, you must correct the application and resubmit it to Grants.gov before the deadline date and time.

If, for any reason, an application is submitted more than once, prior to the application due date, HRSA will only accept the applicant's last electronic submission prior to the application due date as the final and only acceptable submission of any competing application submitted to Grants.gov.

Tracking your application: It is incumbent on the applicant to track application status by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking your application can be found at <http://www07.grants.gov/applicants/resources.jsp>.

V. APPLICATION REVIEW INFORMATION

1. Review and Eligibility Screening Process

An external stakeholder advisory panel will be convened to objectively review THCGME applicants for qualification and eligibility. The advisory panel will verify organizational eligibility and program accreditation status. The Division of Medicine and Dentistry will review each THCGME Program application for eligibility including accreditation status, completeness, accuracy and compliance with the requirements outlined in the funding opportunity announcement. Applications will also be reviewed within HRSA by grants management officials (business and financial review) for content and response to the application requirements.

2. Anticipated Announcement and Award Dates

The anticipated announcement date is January 15, 2011 for payments to be awarded by July 1, 2011. The announcement date will enable THC awardees to offer these new residency training slots through the National Residency Match Program.

VI. Award Administration Information

1. Award Notices

The Notice of Grant Award (NGA) sets forth the amount of funds granted, the terms and condition of the grant, the effective date of the grant, the budget period for which initial support will be given, and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant agency's Authorized Representative and reflects the only authorizing document. The anticipated announcement date is January 15, 2011. The initial period of support and budget period will be July 1, 2011 through September 30, 2011. Federal Fiscal Year 2012 funds will be available through a post-award action that will provide payments for expenses incurred through September 30, 2012.

2. Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 [Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations](#) or 45 CFR Part 92 [Uniform Administrative Requirements For Grants And Cooperative Agreements to State, Local, and Tribal Governments](#), as appropriate.

HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes, as applicable, any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at <http://www.hrsa.gov/grants/>. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory,

regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

Cultural and Linguistic Competence

HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care published by HHS. This document is available online at <http://www.omhrc.gov/CLAS>.

Trafficking in Persons

Awards issued under this funding opportunity announcement are subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to <http://www.hrsa.gov/grants/trafficking.html>. If you are unable to access this link, please contact the Grants Management Specialist identified in this funding opportunity to obtain a copy of the Term.

National HIV/AIDS Strategy (NHAS)

The new National HIV/AIDS Strategy (NHAS) has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce their potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to reduce HIV infection in high-risk communities and reduce stigma and discrimination against people living with HIV.

To ensure success, the NHAS requires the Federal government and State, tribal and local governments to increase collaboration, efficiency, and innovation. Therefore, to the extent possible, THC program activities should strive to support the three primary goals of the National HIV/AIDS Strategy.

PUBLIC POLICY ISSUANCE

HEALTHY PEOPLE 2020

Healthy People 2020 is a national initiative led by HHS that set priorities for all HRSA programs. The initiative has two major goals: (1) to increase the quality and years of a healthy life; and (2) eliminate our country's health disparities. The program consists of 28 focus areas and 467 objectives. HRSA has actively participated in the work groups of all the focus areas, and is committed to the achievement of the Healthy People 2020 goals.

Healthy People 2010 and the conceptual framework for the forthcoming Healthy People 2020 process can be found online at <http://www.healthypeople.gov/>.

Smoke-Free Workplace

The Public Health Service strongly encourages all award recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. Further, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

3. Reporting

The successful applicant under this funding opportunity announcement must comply with the following reporting and review activities:

a. Payment Management Requirements

Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized funds for the grant. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to www.dpm.psc.gov for additional information.

b. Status Reports

1) **Federal Financial Report.** The Federal Financial Report (SF-425) is required within 90 days of the end of each budget period. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through EHB. More specific information will be included in the Notice of Award.

2) **Federal Fiscal Year-end Report.** The awardee must submit a report for the Federal Fiscal Year to HRSA on an annual basis. The Report must include the following information for the residency academic year completed immediately prior to the Federal Fiscal Year:

- The accredited residency training program(s) operated by the qualified THC
- The number of approved part-time or full-time equivalent resident training positions in the qualified THC.
- The number of primary care physicians and dentists who completed their residency training in the qualified THC. Include the number of THC graduates who currently care for vulnerable populations and/or provide care in underserved areas.
- Other information as deemed appropriate including, but not limited to, resident demographics, rural background, and medical education.

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Kim Ross, Grants Management Specialist
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 11A-02
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-2353
Fax: (301) 443-6343
Email: kross@hrsa.gov

Additional information related to the overall program issues and/or technical assistance regarding this funding announcement may be obtained by contacting

Dr. Frederick Chen
Senior Advisor, BHP, HRSA.
Attn: THCGME Program
BHP, HRSA
Parklawn Building, Room 9A-27
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-9235
Fax: (301) 443-8890
Email: FChen@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding Federal holidays at:

Grants.gov Contact Center
Phone: 1-800-518-4726
E-mail: support@grants.gov

VIII. Other Information

Technical Assistance

Two technical assistance calls have been scheduled to help applicants understand, prepare and submit a grant application. The calls will be recorded and will remain available until after the closing date of December 30, 2010. Applicants will have an opportunity to ask questions. The conference calls will be held as follows:

- 1) Focus on application content:
December 7, 2010, 1-3 PM Eastern
Toll-free Number: 1-888-790-2035
Password: Teaching Health Centers
Taped Replay information: 1-866-491-2943

- 2) Focus on systems technical assistance issues:
December 21, 2010, 1-3 PM Eastern
Toll-free Number: 1-888-469-0494
Password: Teaching Health Centers
Taped Replay information: 1-800-469-0494

In addition, frequently asked questions and answers will be posted at <http://www.bhpr.hrsa.gov/grants/medicine.htm>.

IX. Tips for Writing a Strong Application

A concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at: <http://www.hhs.gov/asrt/og/grantinformation/apptips.html>.